UNITED STATES DEPARTMENT OF THE INTERIOR
MINERALS MANAGEMENT SERVICE
GULF OF MEXICO REGION

ACCIDENT INVESTIGATION REPORT

1. OCCURRED
   DATE: **15-OCT-2008** TIME: **1400** HOURS

2. OPERATOR: **Chevron U.S.A. Inc.**
   REPRESENTATIVE: **George, Noel**
   TELEPHONE: **(985) 773-6542**
   CONTRACTOR:
   REPRESENTATIVE:
   TELEPHONE:

3. OPERATOR/CONTRACTOR REPRESENTATIVE/SUPERVISOR ON SITE AT TIME OF INCIDENT:

4. LEASE: **G03336**
   AREA: **ST** LATITUDE:
   BLOCK: **35** LONGITUDE:

5. PLATFORM: **E**
   RIG NAME:

6. ACTIVITY:
- [ ] EXPLORATION(POE)
- [X] DEVELOPMENT/PRODUCTION (DOCD/POD)

7. TYPE:
- [ ] HISTORIC INJURY
  - [ ] REQUIRED EVACUATION
  - [ ] LTA (1-3 days)
  - [ ] LTA (>3 days
  - [ ] RW/JT (1-3 days)
  - [ ] RW/JT (>3 days)
  - [ ] Other Injury
- [ ] FATALITY
- [ ] POLLUTION
- [ ] FIRE
- [ ] EXPLOSION

LWC
- [ ] HISTORIC BLOWOUT
- [ ] UNDERGROUND
- [ ] SURFACE
- [ ] DEVERTER
- [ ] SURFACE EQUIPMENT FAILURE OR PROCEDURES

COLLISION [ ] HISTORIC [ ] >$25K [ ] <=$25K

- [ ] STRUCTURAL DAMAGE
- [X] CRANE
- [ ] OTHER LIFTING DEVICE
- [ ] DAMAGED/DISABLED SAFETY SYS.
- [ ] INCIDENT >$25K
- [ ] H2S/15MIN./20PPM
- [ ] REQUIRED MUSTER
- [ ] SHUTDOWN FROM GAS RELEASE
- [ ] OTHER

6. OPERATION:
- [X] PRODUCTION
- [ ] DRILLING
- [ ] WORKOVER
- [ ] COMPLETION
- [ ] HELICOPTER
- [ ] MOTOR VESSEL
- [ ] PIPELINE SEGMENT NO.
- [ ] OTHER

8. CAUSE:
- [X] EQUIPMENT FAILURE
- [ ] HUMAN ERROR
- [ ] EXTERNAL DAMAGE
- [ ] SLIP/TRIP/FALL
- [ ] WEATHER RELATED
- [ ] LEAK
- [ ] UPSET H2O TREATING
- [ ] OVERBOARD DRILLING FLUID
- [ ] OTHER _____

9. WATER DEPTH: **52** FT.

10. DISTANCE FROM SHORE: **12** MI.

11. WIND DIRECTION: **SE**
    SPEED: **12** M.P.H.

12. CURRENT DIRECTION: **E**
    SPEED: **5** M.P.H.

13. SEA STATE: **2** FT.

17. DESCRIBE IN SEQUENCE HOW ACCIDENT HAPPENED:

On the morning of October 16,2008, the boat arrived at South Timbalier Block 35 Platform E with groceries on board. The crane operator completed his crane pre-use inspection and JSA for the task. Everything was unloaded from the boat and placed onto the structure's upper deck. The platform operator noted that the groceries were sent out in a different container than normal (larger box). Because of the size of this grocery box, it could not be lowered onto the living quarters deck to be unloaded. Later in the morning, the operators elected to transfer the items into a cargo net and lower them to the living quarters deck (this mitigated the safety hazard of many trips up and down the stairs). After completing another crane pre-use inspection (including checking all safety devices on the crane) and another JSA for the task, the crane operator stated that he began moving the cargo net into position in front of the cargo box to allow transfer of said items, which required swinging and booming simultaneously. As he was booming up, he heard the boom contact the stops and immediately hit the boom "up" lever to stop the upward travel of the boom. The operator noted that the right side boom stop was badly bent and that the boom had a slight ding in the top of the right side boom cord. The operator placed the boom back into the boom rest and placed the crane out of service.

18. LIST THE PROBABLE CAUSE(S) OF ACCIDENT:

The boom did not fully come in contact with the hydraulic boom high angle kick out valve.

19. LIST THE CONTRIBUTING CAUSE(S) OF ACCIDENT:

The model of crane involved was manufactured with a boom heel pin bore that was machined into the body of the upper revolving structure. With the boom secured to the upper revolving structure, the heel pin design allows about 1 3/4" of side to side boom movement. When the boom is raised to a preset position it contacts the high angle kick out valve (Note- this valve is supplied with a spring type plunger assembly). In normal operation, when the boom contacts the kick out valve, they observed that it only matched up to about 1/3" of the surface of the spring plunger. When they re-created the lift that the operator stated he was making, when the boom was bent, the boom shifted all the way to one side of the heel pin (i.e. the boom moved the total amount of allowable travel 1 ¾" toward the crane operator). The shift of position of the boom allowed the boom to completely miss the surface of the spring plunger of the high angle boom kick out valve.

20. LIST THE ADDITIONAL INFORMATION:

N/A

21. PROPERTY DAMAGED:

There was a slight bend in the heel boom section.

NATURE OF DAMAGE:

The heel boom section needed to be replaced.

ESTIMATED AMOUNT (TOTAL): **$15,000**

22. RECOMMENDATIONS TO PREVENT RECURRANCE NARRATIVE:

Due to the specific nature of this inccident, the Houma District has no reccomendations for the Regional office.

23. POSSIBLE OCS VIOLATIONS RELATED TO ACCIDENT: **NO**

24. SPECIFY VIOLATIONS DIRECTLY OR INDIRECTLY CONTRIBUTING. NARRATIVE:

None.

25. DATE OF ONSITE INVESTIGATION:

26. ONSITE TEAM MEMBERS:

Casey Bisso /

29. ACCIDENT INVESTIGATION PANEL FORMED: **NO**

OCS REPORT:

30. DISTRICT SUPERVISOR:

Bryan A. Domangue

APPROVED

DATE: **04-DEC-2008**